Column 3 Other. This column should include all expenses which do not appropriately go in either column 1 or column 2.

Column 4 Total. Column 4 should report the total of columns 1, 2, and 3.

Column 5 Reclassifications. This column is used to reclassify expenses among the cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on the form are maintained in the FQHC's accounting books and records in one cost center. An example of a reclassification is the allocation of physician compensation from health care cost to overhead administration cost for the portion of his compensation related to overhead administration. Reductions to expenses should be shown in brackets (< >). The net total of reclassifications on line 7 in column 5 should equal zero.

Column 6 Total Expense (Unadjusted). Column 6 should report expenses before adjustments. This column should equal the total of columns 4 and 5.

Column 7 Adjustments. Adjustments to expenses should be entered in column 7. A schedule must be attached to describe any adjustments made. Adjustments should include reductions

to expense for non-reimbursable costs. Reductions to expenses should be shown in brackets (< >).

Column 8 Total Expense. Column 8 is the FQHC expense after all reclassifications and adjustments. This column should report the total of columns 6 and 7.

The expenses for the purpose of this report are broken down between cost centers for direct health care costs, which includes both core health care costs, line 1, and other ambulatory services, line 2; clinic overhead costs, line 4; non-reimbursable costs, line 5; and outstationed eligibility workers cost, line 6. Line 3 is reserved for total direct health care costs and line 7 is reserved for total all costs, both reimbursable and non-reimbursable.

Line 1. Core Health Care Costs. Expenses to be reported on lines 1 through 1-07 are those costs directly related to core health care services as defined by OBRA '89 section 6404. Core health care services include the following services: physician services, nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Core health care services also

includes, in the case of an FQHC located in an area which is designated by the MSDH to have a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies frunished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment which meets OBRA '89 requirements.

The costs reported on line 1 should include depreciation or rent expense for equipment, as well as, malpractice liability insurance premiums as apportioned in CFR 413.56(a) and (b) to the extent that the costs are directly related to core health care services.

Line 2. Other Ambulatory Services. These include costs associated with any clinic service other than core health care services allowed in the State's Medicaid Plan when offered by the FQHC. In addition to compensation and other directly related costs, the costs reported on line 2 should include depreciation or rent expense for equipment, as well as, malpractice liability insurance premiums as apportioned in CFR 413.56(a) and (b) to the extent that the costs are directly related to other ambulatory services provided.

Line 2-01, Pharmacy. This line should include only those costs associated with maintaining a pharmacy within the clinic. Any costs associated with a contract agreement between the clinic and an outside pharmacy should be reported on line 5-09.

Line 2-02, Dental Services. The allowable cost includes only expenses incurred by a dentist, employed by salary or by contractual agreement, working as a part of the FQHC.

Line 2-05, EPSDT Treatment Services. The amounts to be reported on this line include the EPSDT treatment services which are otherwise not within the scope of allowable services in the State Medicaid plan. All services for EPSDT treatment which are covered by the State Medicaid Plan should be included on the appropriate row of lines 1 and 2.

Line 3. Total Direct Health Care Costs. This is the total of lines 1-07 and 2-07.

Line 4. Clinic Overhead Costs. This line should include those costs associated with managing and maintaining the health center. It should include all allowable costs not

TN 90-08 SUPERSEDES
TN NEW
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directly related to patient care. All costs which can be directly associated to core health care services or other ambulatory services should be reclassified to the proper cost center in column 5.

Line 5. Non-Reimbursable Costs. These include FQHC expenses which are not directly or indirectly related to core and other ambulatory services allowed by the State Medicaid Plan or as a result of services provided as a part of an EPSDT treatment. Non-reimbursable costs include, but are not limited to, the cost centers listed on Form 4, page 3 of 3. It is possible that a cost center listed on line 5 does not apply to a particular facility. For example, if a FQHC pharmacy cost is allowed on Form 4, line 2-01, then it is possible that no pharmacy cost would be included on line 5-09.

Line 6. Outstationed/Eligibility Workers Cost. This line should report the center's share of costs to employ assigned outstationed/eligibility workers.

Line 7. Total Costs. This line should report for each column the total of Form 4, lines 3, 4-17, 5-13, and 6.

FORM 5 - PROVIDER STAFF, VISITS AND PRODUCTIVITY

Please provide the provider name, and number and the report period. The data reported on this form 5 must be actual based on center records.

Form 5 is used to record the provider full-time equivalents (FTE's) of FQHC services personnel and to summarize the number of FQHC visits furnished by the health care staff. The all-inclusive rate for FQHC's is subject to tests of reasonableness. One test is productivity screening guidelines intended to identify situations where costs will not be allowed without acceptable justification by the center and limits on the amount of payment. Data is reported in Part A of the form. Parts B and C are used to apply the productivity screen on determination of provider visits to be used for rate determination. This form's data must EXCLUDE statistics for on-site hours and visits for non-reimbursable cost centers and the overhead cost centers.

PART A - FQHC PROVIDER STAFF AND VISITS

FTE Personnel - Enter the full-time equivalent (FTE) personnel of each type of center health care staff. The number of full-time equivalent employees of each type of staff is determined by the

following formula: divide the total number of hours per year worked by all employees of that type by the **greater** of 1) the number of hours per year one staff member of that type must be compensated to meet the center's definition of a full-time employee or 2) 1,600 hours per year. Fractional equivalents should be shown to the first decimal place. Column 1 is for health care personnel employed under contract and column 2 is for health care personnel who are permanent salaried employees of the center. Column 3 should show the sum of columns 1 and 2.

Visits - Enter the actual number of visits provided to center patients for health services during the reporting period. The visits should be separated for reporting between on-site and off-site. Columns 4, 5, and 6 should include the data for all center patients, including Medicaid patients. Columns 7, 8, and 9 should include data for Medicaid patients only. A visit is defined as a face-to-face encounter between a center patient and a health professional during which an FQHC service is furnished. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

Off-site visits include hospital initial visits as well as follow-up visits within the hospital including, but not limited to, obstetrical deliveries and surgical procedures by center physicians for center patients. Off-site visits include also home health visits by FQHC staff where home health visits are deemed an allowable FQHC service.

Positions

Line 1. Physicians. This includes all medical doctors (M.D.'s).

Line 2. Midlevels. This includes all midlevel staff involved in patient care. Midlevel staff includes the nurse practitioners.

Line 3. Subtotal. This should reflect the sum of lines 1 and 2 in all columns.

Line 6. EPSDT Service Personnel. Include the full-time equivalents of personnel who perform EPSDT services which are not otherwise allowed by the State Medicaid plan.

Line 14. Total. Please total lines 3 through 13 and record the total on this line.

PART B - MINIMUM MEDICAL TEAM PRODUCTIVITY

After completion of Part A on Form 5, fill in the number of visits and full time equivalents as instructed on lines 1 through 4 of

Part B.

Line 1. Total Physician and Midlevel Visits. Enter the number of physician and midlevel staff visits recorded on Part A, column 6, line 3.

Line 2. Total Medical Team FTE's. Enter the number of full-time equivalents for the physician and midlevel medical team. For purposes of this determination, record the sum of the physician FTE's recorded on Part A, column 3, line 1 plus one-half the midlevel FTE's recorded on Part A, column 3, line 2.

Line 3. Minimum Medical Team Productivity. Multiply the number of FTE's recorded on line 2 times the productivity level of 3,500 visits per full-time equivalent and enter the product here.

Line 4. Physician and Midlevel Visits to be Used in Rate Determination. Enter the greater of the number recorded on line 1 or line 3 to determine the physician and midlevel visits to be used in combination with Part C, line 1 in the rate computation.

PART C - PROVIDER VISITS FOR RATE DETERMINATION

Line 1 - Total Provider Visits Less Physician and Midlevel Visits. Enter the difference between total provider visits recorded in Part A, column 6, line 14 (Total) and Part A, column 6, line 3 (Subtotal).

Line 2 - Total Provider Visits for Rate Determination. Enter on this line the sum of Part B, line 4 and Part C, line 1. This number is the total provider visits to be used in the rate computation on Form 6.

FORM 6 - OVERHEAD ALLOWABILITY AND RATE DETERMINATION

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS

There is an applied limit on overhead costs of thirty (30) percent of total FQHC costs. The limit is imposed in order to define reasonableness of costs to be reimbursed. The limit (or screening guideline) to be imposed, if any, is calculated in Part A of this form. The source of the amount to be entered on each line in Part A is listed on the line and is as follows:

Line 1. Total Direct Costs of FQHC Services. Enter the amount from Form 4, page 1 of 3, column 8, line 3.

Line 2. Outstationed/Eligibility Workers Cost. Enter the amount